Drug Medi-Cal MONITORING NEWS

* SPECIAL EDITION *

COMMON DEFICIENCIES IN POSTSERVICE POSTPAYMENT UTILIZATION REVIEWS

DMC Monitoring Staff:

Gloria Woodlock
Supervisor,
DMC Monitoring Section
(916) 322-1935
gwoodlock@adp.state.ca.us

Bruce Cherubin
Analyst
(916) 322-6694
bcherubin@adp.state.ca.us

Jim Cortese
Analyst
(916) 327-9503
jcortese@adp.state.ca.us

JoAnn Coughlin
Analyst
(916) 323-0307
jcoughlin@adp.state.ca.us

Lorna Flores
Analyst
(916) 327-7050
lflores@adp.state.ca.us

Gwen Nicholas
Analyst
(916) 445-5529
gnicholas@adp.state.ca.us

Clyde Steele
Analyst
(916) 323-1874
csteele@adp.state.ca.us

Elena Valencia
Analyst
(916) 327-9225
evalencia@adp.state.ca.us

The DMC Monitoring Section conducts unannounced PSPP utilization review visits to DMC providers to ensure that providers meet the requirements of Title 22 of the California Code of Regulations, (Sections 51341.1, 51490.1 and 51516.1). When deficiencies in meeting the requirements of Title 22 are found, recoupments are taken as required by Title 22, Section 51341 (k).

In order for PSPP reviews not to result in the recovery of payments, providers must institute quality assurance steps to ensure that all of the Title 22 DMC requirements are completely followed. Payments must be recovered for all DMC units of service provided when not in full compliance with the regulations. In some cases, recovery may be for the entire treatment episode. This special issue of *DMC Monitoring News* outlines the importance of following all of the requirements contained in CCR, Title 22, Section 51341.1 and 51490.1 and the fiscal repercussions that will result when the regulations are not followed.

In keeping with the Department of Alcohol and Drug Program's (ADP) mandate to enforce the DMC regulations and our commitment to minimize recoupments and provide technical assistance to DMC providers, we have listed below the areas in which the large majority of recoupments are taken. We strongly recommend that providers examine their program quality assurance efforts to ensure procedures adequately address all of the Title 22 requirements in order to avoid recoupments.

DMC is medically based treatment funded in part by federal Medicaid. Therefore, it is critical to establish the medical necessity for treatment in order for DMC to reimburse substance abuse treatment services.

Admission to Treatment

Title 22, Section 51341.1 (h) (1) (A) (i) requires the provider to develop and use admission criteria and procedures. The PSPP review evaluates whether the provider is following its own admission criteria and procedures. Developing and using admission criteria are one of the requirements of the Title 22 regulations and establishes medical necessity for treatment services. Programs that do not have admission criteria and procedures, or which do not follow them, face major recoupments, because medical necessity has not been established.

Title 22, Section 51341.1 (h)(1)(A)(iii) requires the provider to complete an assessment of the physical condition of the beneficiary. The assessment of the physical condition of the beneficiary is the single most common cause of recoupments during PSPP reviews.

The assessment is accomplished by:

1. The completion of a physical exam within 30 days of the admission to treatment date (with the original or a copy of the exam placed in the patient record); or
2. the physician's completion of a waiver of the admission physical exam stating that he/she has reviewed the beneficiary's medical history, substance abuse history and/or the beneficiary's most recent physical exam.

If a waiver is used, the patient record must document that the physician reviewed the beneficiary's medical history, substance abuse history and/or the beneficiary's most recent physical exam and the waiver must state the basis for not requiring a physical examination.

Process for Establishing Medical Necessity for Treatment

Title 22 requires the recoupment of all billings for a treatment episode if any of the elements of Section 51341.1(h) (1) are missing or incorrect. While the provider has 30 days to complete the admission process, payments for services provided during the first 30 days of service for which medical necessity was never established cannot be retained. Following the proper admission sequence is critical to establishing medical necessity. Establishing medical necessity is the bedrock on which all of the requirements of Title 22 are built. The medical director/physician is the only person who can establish medical necessity. The appropriate Diagnostic and Statistical Manual of Mental Disorders (DSM) code (revised 3rd or 4th Edition) on the patient record must be present in addition to a number of other steps to establish medical necessity. [1] If any part of the admission process is completed incorrectly, recoupments must be taken for the entire treatment episode because medical necessity for the beneficiary's treatment has not been established. Due to the short length of time for most Outpatient Drug Free (ODF) treatment programs (90 to 180 days) and the frequency of beneficiaries dropping out of programs during early stages of treatment, it can be particularly challenging to meet all of the requirements for admission and establish medical necessity. It is highly recommended that before claims are submitted, providers review their admission process to ensure that all the requirements of the Title 22 regulations are met.

Treatment Planning

Title 22, Section 51341.1(h) (2) (A) requires the initial treatment plan to be based on the information obtained during the intake and assessment process. Treatment plans are reviewed in detail to verify that they address all significant problems documented in the assessment material. It is required that treatment plans be individualized and not "boilerplate" plans. Treatment plans that are not individualized and/or do not address all significant problems identified during the assessment process do not meet the requirements and all payments for services provided under a deficient treatment plan are subject to recovery of payments.

Title 22, Section 51341.1(h) (2) (A) (i) (f) requires that the treatment plan include the assignment of a primary counselor for the beneficiary. The treatment plan must explicitly state that a particular individual has been assigned as the primary counselor for each beneficiary. A signature block titled "Primary Counselor" is not acceptable as sufficient documentation of the assignment of the primary counselor; the chart must also list the name

[1] Title 22, Section 51341.1, sub-section (h) (1)

signature. The patient record will be reviewed to make sure that a primary counselor has been assigned to each client as required by the regulations. Recoupments are taken if there is no assignment of a primary counselor.

Title 22, Section 51341.1(h) (2) (A) (iii) (a) requires that the treatment plan be updated at least every 90 days or when a change in problem identification or focus of treatment occurs. To ensure that programs are updating treatment plans as appropriate, all progress notes in the file will thoroughly reviewed. If the progress notes identify a significant change in problem identification or focus of treatment, but the treatment plan is not updated, payments for services provided without the updated treatment plan are recovered. The updated treatment plan is the documentation that the physician is aware of the change in problem identification or treatment focus and continues to approve the client's treatment.

Progress Notes

Progress notes must fully describe the progress or lack of progress resulting from the counseling provided to clients. Simple statements of fact, i.e. "the client attended group and participated," is not sufficient documentation.

Individual counseling sessions in ODF are often incorrectly identified and billed as crisis intervention counseling sessions. Title 22, Section 51341.1(b) (5) defines a crisis intervention counseling session. A common deficiency noted during PSPP reviews occurs when individual sessions billed to DMC and identified as crisis intervention do not qualify as such because all of the elements of crisis intervention as defined by the regulations were not documented in the progress notes. Individual counseling for crisis intervention must meet the following definition as described in the regulations:

- "An actual relapse" or,
- "An unforeseen event or circumstance, which presents an imminent threat of relapse" and,
- "Crisis intervention services shall be limited to stabilization of the beneficiary's emergency situation."

If an individual never stopped abusing a substance, they cannot be considered to be relapsed. Also, note the word "unforeseen"; that is, a problem occurs that is not anticipated. A problem being addressed on a treatment plan cannot justify a crisis intervention session unless there is an actual relapse. The client's desire to abuse a substance is the whole reason for treatment, and therefore, is not a crisis if the problem precipitating the threat of relapse is already manifested by the client or is a new phase of an ongoing problem. Also, the language "shall be limited to stabilization" strictly limits the individual session to stabilization of the emergency situation and not ongoing treatment for a new problem. Ongoing treatment for newly identified problems should be addressed through an update of the beneficiary's treatment plan, revised counseling recommendations, and/or referrals.

Individual counseling sessions in ODF used for treatment planning, if billed to DMC, must result in a treatment plan or updated treatment plan or the session cannot be reimbursed by DMC. The regulations clearly require that the treatment plan be produced as a result of the individual counseling session. While in the past there has been a lack of clarity about whether an actual treatment plan had to be produced as justification for the individual session and it was thought by some that there might be situations that would justify an

counseling session or sessions identified as treatment planning may only be billed to DMC if an actual treatment plan or updated plan is created as a result of the session. The most common improper billing for an individual session identified as treatment planning is one in which the beneficiary's progress in treatment is reviewed, but no updated treatment plan results. While there is certainly clinical justification for this type of session for treatment planning, it is not part of the treatment planning process that is reimbursed by DMC outlined in the regulations, nor is it reimbursable by DMC as a treatment planning individual counseling session unless a treatment plan is actually produced as a result of the session for which billing has been submitted.

Provider and Beneficiary Contact

Title 22, Section 51341.1(h) (4) and (i) (4) describe the minimum provider and beneficiary contact and how a waiver of the minimum contact by the physician must be documented. *O*nly the program physician may waive the requirement for minimum contact between the counselor and client. Such waivers must be documented in the beneficiary's treatment plan.

In the event that a program does not provide the minimum number of treatment contacts required by the regulations, or document a waiver of the minimum contact by the program Physician, payments for services that do not meet the required minimum will be disallowed and recouped.

Discharge Summary

Title 22 requires the disallowance and recoupment of all claims for services from an entire treatment episode if the discharge summary is incomplete or missing. Title 22, Section 51341.1(i), lists documents that must be maintained in the individual patient record for the provider to "…receive and retain reimbursement for services…" A common deficiency noted during PSPP reviews is a missing or incorrect (incomplete) discharge summary. Many discharge summary forms used by providers do not collect the information required by Title 22. Providers are strongly encouraged to review their form against the requirements of Title 22, Section 51341.1(h) (6), to ensure that all required elements are present. Providers may also wish to use the sample discharge available at http://www.adp.ca.gov/dmc/pdf/Discharge_Summary_20050318.pdf on the ADP web site.

Good Cause Codes

Title 22 requires that claims for DMC services be submitted no more than 30 days after the end of the month of service. Good cause codes are the letters A, B, C, D, E, and F, and are used to document the reason that a DMC claim was submitted beyond the deadline of 30 days after the end of the month the service was provided. Title 22, Section 51341.1(m) (1) (D) requires that overpayments be recovered if the provider "Used erroneous, incorrect, or fraudulent good cause codes and procedures specified in Sections 51008 and 51008.5." Claims identified as using incorrect Good Cause Codes will be disallowed and payments recouped. Providers are encouraged to review the requirements for the correct use of Good

Multiple Billing Requirements

Some programs do not place the ADP form 7700 in the beneficiary's record. Title 22, Section 51490.1(d), requires that a Multiple Billing Override Certification (ADP form 7700) be completed and placed in the beneficiary's individual record any time that a multiple billing override code is used in submitting a claim for a second service on the same calendar day. Title 22 limits payments for DMC services on a single calendar day and imposes extra documentation requirements on programs when they submit claims for more than one service on a calendar day. One of these requirements is that a person authorized to represent the county or provider signs the form 7700, "…certifying that a review of the client's record substantiated the multiple services."

Providers must place the ADP Form 7700 in the beneficiary's individual patient record; if it is not in the record during a PSPP review, the second service will be disallowed and the payment recouped.

Compliance with Requirements for Specific Treatment Services

Some providers do not document that they have made available all the services required by the regulations for the treatment modality, which results in recovery of payments.. **Providers should review the requirements of Title 22, Section 51341.1(c) & (d), and ensure that the individual patient record of each beneficiary adequately documents that all required services were available and offered to each beneficiary.** Perinatal Certified providers should pay particular attention to Section 51341.1(c), sub-sections (3) and (4). Failure to document that the full range of these services were offered to the client may result in disallowance and recoupment of the entire treatment episode.

For more information:

Updated information, sample forms and other resources regarding DMC can be found on the Department of Alcohol and Drug Program's web site at:

http://www.adp.ca.gov/dmc/dmc_resource_tool_kit.shtml

Specific questions can be e-mailed to DMC staff at **DMCanswers@adp.state.ca.us** .